Cornerstones for Developing a Care Manager Orientation

STATE INNOVATION MODEL PATIENT CENTERED MEDICAL HOME INITIATIVE OFFICE HOURS

6.20.18
Team Members

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Objectives

- Describe the 3 Cornerstones of a Care Manager (CM) orientation
- Identify Michigan Data Collaboration resources
- Identify resources for Care Manager orientation
Housekeeping: Webinar Toolbar Features

Your Participation

Open and close your control panel

Join audio:
• Choose **Mic & Speakers** to use VoIP
• Choose **Telephone** and dial using the information provided

Submit questions and comments via the Questions panel

**Note:** If time allows, we will unmute participants to ask questions verbally.
• Please raise your hand to be unmuted for verbal questions.

**NOTE:** In the event that there is not time to answer questions live, all questions submitted via the Question Function of the GoToWebinar toolbar will be recorded, an FAQ generated and posted to our webpage.
Questions for Participants

What are your *key challenges* in providing Care Manager orientation?

What are your *key learnings* in providing Care Manager orientation?
Definition of Care Management

“Care management programs apply systems, science incentives and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage medical, social, and mental health conditions more effectively.”

The Care Manager Position

Consider the Care Manager position in an ambulatory care environment.

- What are the *skills and experience* of the newly hired Care Manager?

- What *knowledge and skills are needed* to be successful in the Care Manager role?
Interview – Setting the Expectation

The importance of describing the Care Manager role extensively

- Describe care manager orientation

- Care Manager: Identify performance expectations for the care manager; care manager responsibilities, productivity, tracking and monitoring codes

- Primary care practice: quality and utilization metrics, SIM PCMH Initiative
Orientation vs. Onboarding

*Orientation* – more administrative in nature and typically involves the completion of new hire paperwork, enrolling in benefit plans and learning the mission, values and vision of the organization.

*Onboarding* – long term focus aimed at identifying training needs, setting performance goals, providing on-going feedback, and ensuring the new employee is a positive addition to your team.

➤ When used together, orientation and onboarding help establish organizational commitment, clarity of job tasks, and job satisfaction.

Sims, Gloria (2018). Orientation vs Onboarding, The Insperity Guide to Employee Engagement, Issue 1
What are the benefits of an effective orientation and onboarding process?

1. Reduces start up costs, helping employees get up to speed more quickly
2. Helps to reduce employee anxiety
3. Improves employee retention
4. Saves time of supervisor
5. Develops realistic job expectations
6. Improves employee satisfaction

Sims, Gloria (2018). Orientation vs Onboarding, The Insperity Guide to Employee Engagement, Issue 1
The Results of MiCMRC Complex Care Management Course Poll

Orientation Satisfaction

- Not at All
- Fair
- Moderate
- Highly

Number of Respondents
Care Management Orientation: SIM PO and Practice Leaders Key Learnings

- Coaching, networking and mentoring
  - CM peer group meetings
  - One to one meetings frequently with CM and preceptor/supervisor

- Shadowing

- Identifying care management patient enrollment criteria
  - “practice staff, providers, and CM all on the same page”

- Sharing care management metrics and data
## Care Management Strategies for the Practice

<table>
<thead>
<tr>
<th>Identify Populations with Modifiable Risks</th>
<th>Align CM Services to the Needs of the Population</th>
<th>Identify and Train Personnel Appropriate to the Needed CM Services</th>
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</thead>
<tbody>
<tr>
<td>• Use Multiple metrics to identify patients with modifiable risks</td>
<td>Tailor CM services, with input from patients, to meet specific needs of populations with different modifiable risks</td>
<td>• Determine who should provide CM services given population needs and practice context</td>
</tr>
<tr>
<td>• Develop risk-based approaches to identify patients most in need of CM services</td>
<td>Use EMR to facilitate care coordination and effective communication with patients and outreach to them</td>
<td>• Identify needed skills, appropriate training, and licensure requirements</td>
</tr>
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<td></td>
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<td>• Implement interprofessional team-based approaches to care</td>
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</table>
The 4 phases of onboarding

1. Pre hire preparation – from the time of job acceptance to the first day on the job
2. Introductions – official welcome of your new or transferring employee
3. 1-90-days; evaluation period
4. 90 days through at least the first year

www.insperity.com/blog/employee-onboarding-vs-orientation-need/
Pre-hire

What should be ready...

1. Develop an orientation checklist specific to your organization
2. Ensure that there is a functional workspace ready for the employee
3. Ensure the employee has proper equipment and supplies
4. Provide a welcoming environment
Introductions

- Introduce Care Management to all practice staff; the what, the why, and the how
- Introduce the Care Manager to all practice staff
- Support the Care Manager to introduce care management services at the practice provider meetings, staff meetings
- Introduce the Care Manager to specialists and other referral sources
- Identify a care management “champion”
The 3 Cornerstones

Key Areas of an Effective CM Orientation

1. Care Management Role
2. Practice
3. Population

Cornerstone: is an important quality or feature on which a particular thing depends or is based.
Orientation to 3 Cornerstones

![Bar chart showing the number of respondents for role, practice, and population Cornerstone orientation provided.]

- Role: 70 respondents
- Practice: 70 respondents
- Population: 50 respondents
1. CARE MANAGER ROLE

CM role and responsibilities in the practice

- Care Manager role and responsibilities in the practice
  - Care Manager responsibilities
  - Care Manager Job description
  - Care Management introduction letter for patients and business cards for care manager

- Care Manager initial training and longitudinal education *
  - Complex Care Manager Course - MiCMRC
  - MiCMRC approved self-management course
  - Longitudinal education

- Care Manager caseload – building and managing
  - Embedment
  - Referral criteria, process and sources
  - Enrollment process and engagement in longitudinal relationships
  - Patient education materials
  - System to schedule enrollment and follow-up visits
  - CM metrics and tracking system
  - Performance feedback for CM – productivity metrics

* Additional information on SIM required CM training can be found in the 2018 PCMH Initiative Participation Guide
Additional Ideas:

- Ramp up the responsibilities and caseload of the CM over time
  - Example - CM focuses on the transition of care visits during the initial orientation phase

- Provide opportunities for CM to learn from internal experts and peers through:
  - Shadow content experts in the first 2 weeks after hire, such as disease management leads; diabetes educators
  - Shadow more experienced CMs according to their strengths
  - Meet 1:1 with staff that interface with care management services and discuss collaboration
  - Partner a new CM with a mentor over the course of 3-6 months
  - Meet 1:1 with preceptor or supervisor weekly
# CM Role

## Care Manager Responsibilities:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
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</table>
- Assessment, management, case closure |
# CM Role

<table>
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<tr>
<th>Care Manager Responsibilities:</th>
<th>Resources:</th>
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<tbody>
<tr>
<td>How do you develop an accurate, appropriate Individualized Care Plan? (using SMART goals, follow up and consistent revamping)</td>
<td>MiCMRC E-Learning Self Study Modules <a href="http://micmrc.org/e-learning">http://micmrc.org/e-learning</a></td>
</tr>
</tbody>
</table>
| What patient educational materials are available in my practice? | MDHHS no cost educational materials: [http://micmrc.org/system/files/3.4%20MDCH_Primary_Care_and_Public_Health_Order_Form_475588_7_0.pdf](http://micmrc.org/system/files/3.4%20MDCH_Primary_Care_and_Public_Health_Order_Form_475588_7_0.pdf)  
MICMRC Chronic Conditions Pages for Heart Failure, COPD, HTN, Asthma, Childhood Obesity, Adult Obesity and Diabetes [http://micmrc.org/topics/chronic-conditions](http://micmrc.org/topics/chronic-conditions) |
2. PRACTICE FRAMEWORK

How things happen in your particular practice

- Identify a champion for care management
- Role and responsibilities of practice staff members, shadowing experiences
- Health care team communication, documentation systems, and tracking codes
- Practice meetings and other communication methods
- Care Manager meetings – CM peer group meetings
- Performance feedback for CM – productivity metrics
- Baseline practice assessment
- Patient access, communication methods, (portal), and education materials
- Specialists utilized frequently by the practice, collaborative agreements
- SIM PCMH Initiative requirements, PCMH designation areas of focus
- Practice policy, procedures, and protocols and evidenced – based guidelines
Additional Ideas:

Involve Care Manager in practice meetings
- Huddles
- Staff meetings
- Case load reviews
- Provider meetings

Identify how care coordination across all team members occurs in relationship to individual patient, community clinical linkages
- Note in EHR
- Care team conference
- Screening results and care plan available in EHR to all team members

Recognize burn-out and staff fatigue
- Provide support for your staff, just as you provide care to your patients and their caregivers
<table>
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<tr>
<th>Practice</th>
<th>Resources:</th>
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<td><strong>Care Manager Responsibilities:</strong></td>
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| What are the SDOH screening tool used by the practice? Practice's SDOH workflow? | SIM Participation Guide 2018  
| What other practice team members are involved with each patient? | Assessment of Team Roles and Distribution / RWJF Leap tool  
| What are the community resources? Who are the community organizations and partners? | Community Resources: Michigan 2-1-1 Information Guide (a resource for SIM PCMH Initiative)  
https://www.michigan.gov/documents/mdhhs/2-1-1_brochure_Final_619035_7.pdf |
| | SIM PCMH Initiative office hours webinar: Michigan 2-1-1 Basic Concepts and Utilization  
https://www.michigan.gov/mdhhs/0,5885,7-339-71551_64491_86032_86033-467622--,00.html |
3. POPULATION

Who are your patients and what are their needs

- Identifying the population who will potentially benefit from care management services
- Accessing data to target the patients who may benefit from care management services
- Introductions to the community resources and linkages used by the practice, operationalizing the Community Clinical Linkages
Additional Ideas

Proactive population management through:

- Planned visits
- Patient outreach
- Gaps in care reports
- Quality metrics, data reports, and quality improvement activities at the practice
- Introduce population health tools
  - MDC patient lists
  - Registry reports
  - SDOH screening
  - Behavioral health screening
## Population

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<td>How are community clinical linkages operationalized: practice work flow, partnerships with community organizations, resources?</td>
<td>MiCMRC recorded self study webinar: The Role of Care Coordinators and Care Managers in Developing and Maintaining Community Linkages</td>
</tr>
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<td><a href="http://micmrc.org/training/developing-and-maintaining-community-linkages">http://micmrc.org/training/developing-and-maintaining-community-linkages</a></td>
</tr>
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<td>How does the practice screen for SDOH? Who does the screening and where does the information go?</td>
<td>For Ideas see SIM Participation Guide 2018</td>
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<tr>
<td>Who contacts the patient to address unmet SDOH needs and who does the follow up once a community linkage is made?</td>
<td>For Ideas see SIM Participation Guide 2018</td>
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Rising Risk and SDOH

- Healthcare providers are in the forefront of addressing SDOH within the scope of patient centered medical home.

- Rising Risk
  - Rising risk patients often have inadequate access to providers or supportive services, (resources are often centered on high-risk patient management)
  - To effectively interrupt the escalation from rising – to high risk, core drivers should be identified to determine intervention:
    - Chronic condition diagnoses
    - Biopsychosocial risk factors
    - Patient levels of health literacy and engagement

*Addressing the Needs of Your Rising-Risk Patients, Executive Summary. 2017 Advisory Board, Population Health Advisor,*
Patient Population Tool – Patient List

Susan Stephan – Senior Business Systems Analyst, Michigan Data Collaborative
Polling Question

Do you currently use the SIM Patient list as part of your orientation to understand your SIM Patient Population?

Yes
No
Don't know
Patient List

• Identify patients with chronic conditions
• Identify high utilizers
• Identify patients new to your practice this month
• Identify patients attributed to your practice but not seen in the last 12 months (New fields as of May 2018!)
• Combination of chronic conditions, high utilizers, and never seen
Demo of Sample Patient List

Key Fields

- # of Inpatient Visits in newest Release
- # of ED Visits
- # of Readmissions
- # of Visits to Any PCP in 12 months
- Most Recent PCP Visit Date

Chronic Conditions:
- Diabetes
- Asthma
- Hypertension
- Obesity

New Patient PO and PU Flags

Useful Excel Options

- Hide columns
- Sort
- Filter

High ED Utilizer
Identifying Patients for Care Management

Monthly list review can uncover patients for care management

Focus on Key Fields

- Chronic conditions to identify largest volume
- High utilizers that have not had a recent planned visit
- Multiple chronic conditions new patients
MiCMRC Care Management Resources

MiCMRC.org - New Orientation website resources
- Examples of: Orientation Checklist
- Orientation Schedule
- CM Job Description
- Care Management Introduction Embedment

MiCMRC Approved Self Management Support Course

Complex Care Management Course
- 6 hour Self-study
- 2 live training days
- CCM Course
- Resource Guide

Care Management 101
- Suggested 1st year: eLearning Modules
- Live and Recorded Webinars
- MiCMRC Website self-study:
  - Topic Pages
  - Chronic Conditions
  - Team Based Care

Longitudinal Education
- Live Webinars
- Recorded webinars
- eLearning Modules
Orientation to coding and tracking resources

Longitudinal learning
• Webinars
• eLearning
Welcome to our new Care Manager Orientation web page!

If you have questions regarding the page, would like to share a tool or resource or leave feedback about the page contact us at micmrc-requests@med.umich.edu

To access the Care Manager Orientation page Click Here
## Future SIM PCMH Initiative Events

| Date        | Event                                | Content                                                        | Presenters                                                                 |
|-------------|--------------------------------------|                                                               |                                                                           |
| July 12, 2018 12 noon – 1:30 pm | SIM PCMH Initiative Quarterly Update | SIM updates, Operationalizing an Effective Care Manager Orientation | Operationalizing CM Orientation:  
  ▪ Ruth Clark, Executive Director – Integrated Health Partners  
  ▪ Jodi Buchholz, Manager of Ambulatory Case Management – Henry Ford Health System  
  ▪ Casidhe Kowalczyk RN, BSN Preceptor - IHA |
| July 18, 2018 12 noon – 1 pm | SIM PCMH Initiative Office Hours     | Utilization Measure Changes New Measures in Release 5 Understanding the Care Management Reports | Susan Stephan – Business Systems Analyst Senior, Michigan Data Collaborative |

Registration for SIM PCMH Initiative Events: [click here](https://www.michigan.gov/sim)
Discussion, Q and A
Contact Us

Michigan Care Management Resource Center: micmrc-requests@med.umich.edu

Michigan Data Collaborative: https://michigandatacollaborative.org/

MDHHS SIM Care Delivery: mdhhs-simpcmh@michigan.gov